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+ Leadership

Dr Gautam Daftary

Founder, Chairman and Managing Director, Aksigen IVF

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* Responsible for selection of news under the PRP Act.

Crisis challenges but also creates new opportunities

Winston Churchill advised: Never let a good crisis go to waste. That advice helped rebuild after World War II and can help leaders cope with present day geopolitical tensions.

The volatile West Asia situation has begun to impact segments of the healthcare sector. Let's consider a few facets. Rising input costs and the helium shortages on the medtech side, and delayed medical value travel on the healthcare services side.

This is yet another wakeup call: to diversify supply routes and vendors and in the case of the latter, strengthen existing patient coordination and explore emerging markets.

While hospitals and patient facilitators will plug the gaps in patient care service, fixing the flaws on the procurement and medical device manufacturing side will not be as easy. Experts have warned of shortages in healthcare consumables like surgical gloves, IV lines, cannulas etc.

The Government of India has already stepped in with some measures, like the temporary exemption of full customs duty on critical petrochemical products until June 30, 2026.

Himanshu Baid, MD, Poly Medicure welcomes the duty waiver, pointing out that raw materials such as polypropylene, ABS, polycarbonate, and PVC resin form the backbone of medical consumables manufacturing, and their exemption provides much-needed relief to domestic manufacturers, especially MSMEs. He also appreciates the recent reversal of the earlier 50 per cent reduction in Remission of Duties and Taxes on Exported Products (RoDTEP) rates as it will significantly enhance the competitiveness of the Indian medical devices industry on the global stage and support export growth.

But the industry is asking for more reforms. While welcoming the temporary exemption of full customs duty, Rajiv Nath, Forum Coordinator, Association of Indian Medical Devices Industry (AiMeD) reiterated his call for temporary GST relief on raw materials.

Nath cites letters sent thru AiMeD to the Ministries, urging them to "intervene decisively on escalating raw material costs—particularly plastics and chemicals essential for medical devices such as disposables, drug delivery systems, and implants."

AiMeD feels that the government's quick action will ensure supply stability, lower input costs, and support uninterrupted production of life-saving devices amid global volatility. It points out that this exemption will benefit not only medical devices but also pharma, packaging, and other downstream industries, ultimately easing burdens on healthcare providers and patients.

AiMeD has also appreciated the sections under the *Jan Vishwas* (Amendment of Provisions) Bill, 2026 passed on April 3, which decriminalise numerous punitive measures previously applied to medical devices under the Drugs & Cosmetics Act, 1940. By replacing imprisonment for minor procedural violations with graded monetary penalties and structured adjudication, AiMeD states that the Bill shifts towards a governance-focused framework with minimal government interference. These changes, including amendments to Sections 27A(ii) and 28A, alleviate the compliance burden, reduce litigation, and foster a trust-based ecosystem that empowers the medical devices industry to innovate and grow while upholding public health safeguards, explains the AiMeD note.

The volatile West Asia situation is yet another wakeup call: to diversify supply routes and vendors and strengthen existing patient coordination while exploring emerging markets

AiMeD expects that these reforms will streamline operations for Indian medical devices manufacturers, enhance global competitiveness, and align with international best practices, ultimately benefiting patients and healthcare delivery across the country,

But patient groups voice other concerns. Prof Bejon Kumar Misra, Founder Director of Patient Safety and Access Initiative of India Foundation, cautions, "*Jan Vishwas* cannot be only for the industry, it has to equally be seen in the favour of the consumers. Trust is the cornerstone for growth, development and transparency. How does the consumer gain from ease of doing business? Do products and services become more affordable, accessible and of high assured quality? Are their complaints heard promptly and efficiently? If yes, then the amendments to the *Jan Vishwas* (Amendment of Provisions) Bill 2026 is most welcome and has our full support."

Radiologists and their clinics have started to feel uneasy as some of their equipment need helium, which generally comes from Qatar. Dr Harsh Mahajan, Mentor, FICCI Health Sector & Founder and Chairman, Mahajan Imaging & Labs explains that the liquid helium shortage, and resulting increased prices, could delay installation of new MRI scanners which require about 1500 litres of liquid helium as the initial fill for the MRI magnets.

Following Churchill's advice, healthcare leaders can build better based on the learnings from this crisis. Tapping new emerging countries while strengthening existing patient-medical establishment trust will work for the medical travel sector. Switching to helium-free MRIs which are more sustainable, both ecologically and economically could be the solution to the helium shortage.

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Davaindia is opening one store every 24 hours across the country to improve accessibility

Making healthcare affordable and accessible remains one of India's biggest priorities. And, **Dr Sujit Paul,** Group CEO, Zota Healthcare, has been working to change how India views generic medicines through initiatives like Zota Healthcare and Davaindia. He shares his journey, leadership learnings, and vision for expanding access to quality healthcare across the country, in a cndid, exclusive conversation with **Lakshmipriya Nair**

Dr Paul, let's begin by getting to know you a little better. We've seen you on major public platforms like TED Talks and Josh Talks, but we would like to know the person behind the leader. Who is Dr Sujit Paul?
I started my journey long ago, primarily from a very grassroots level. I would say sheer hard work, which I continue even today, along with a bit of luck and the support of my family, have made me who I am.

Yes, there is a public persona that people see, but what matters more to me is how I can touch more lives and help build a better world around us. That remains my strongest focus.

There must have been defining moments or incidents that shaped you into who you are today. Could you share some of them?
There are innumerable incidents in everyone's life. However, I believe self-vigour and the intent to do something different truly shape a person. Incidents are simply situations we overcome and learn from.

I strongly believe that whatever I do, I must strive to be the best at it. If you look at my professional journey, I have always tried to ensure excellence in everything I undertake. What matters is how we evolve into a better version of ourselves through those defining moments.

You have mentored and influenced many people over the years. Could you share some lessons from that journey?
For nearly two decades, through sujitpaul.com, we have worked with people across India and globally to help them become better versions of

themselves. Many individuals have overcome low confidence, personal challenges, and self-doubt through coaching and mentoring.

Interestingly, most of this work is free for those who genuinely cannot afford it. Coaching and counselling require deep experience. Someone who has not gone through the full professional journey cannot truly guide others.

Before seeking advice, people should evaluate whether a mentor has actually experienced different stages of growth, at junior, mid-level, senior leadership, across diverse organisations. Experience in the right domain is essential.

So experience is the best teacher?
Experience in the right context is the best teacher. A mentor must have failed, succeeded, learned, and evolved multiple times. Growth comes not from avoiding mistakes but from learning how to bounce back from them.

People who lead often develop certain habits and disciplines. What practices have helped you?
A positive mindset is fundamental. Without it, growth becomes difficult.

Second, surround yourself with the right people. There is a Japanese saying: If you board the wrong train, get down at the earliest station. Associations matter deeply.

If people around you carry negativity, resist learning, or constantly dwell in the past, they may hinder your growth. As you move forward in life, you must sometimes let go of emotional baggage to rise higher.

Great leaders surround themselves with positive thinkers, innovators, and growth-oriented individuals.

India truly needs accessible, affordable healthcare and high-quality generics are central to that mission

Moving to your professional work, Zota Healthcare and Davaindia have worked toward making medicines affordable. So, how can generic medicines gain priority in India?
Consumers must understand the importance of high-quality generic medicines and choose pharmacies fundamentally committed to generics.

At Davaindia, we sell only generic medicines. Our principle is clear. We exist for people who cannot afford expensive branded medicines. Business ethics begin with clarity of purpose.

India truly needs accessible, affordable healthcare and high-quality generics are central to that mission.

Is the Indian market ready for large-scale adoption of generics?
Transitions always take time. Just as people gradually shifted from bank counters to ATMs and later to UPI payments, acceptance evolves slowly.

Physicians, pharmacists, and consumers have long depended on branded medicines. Changing this mindset requires sustained education and awareness, something we are actively working on across urban and rural India.

What role can pharmacy chains play in improving healthcare accessibility?
Responsible companies are key. Healthcare is not just business; it carries social responsibility.

Patriotism is not merely saying "Mera Bharat Mahan." It comes from ensuring that even the poorest citizens can access quality medicines. Many rural citizens struggle to afford basic necessities. Expecting them to purchase expensive branded medicines is unrealistic. Our responsibility is to deepen access across therapeutic segments and geographies.

What major changes do you foresee in pharmacy retail over the next five years?
Artificial Intelligence will play a significant role, especially predictive data analysis and disease management. Pharmacies will increasingly contribute to early disease detection and patient education.

As we speak, Davaindia is opening one store every 24 hours across the country to improve accessibility.

You recently opened over 100 stores in a single day. What does this milestone represent?
While that achievement was significant, consistency matters more. Over the last 500 days, we have opened one store every single day across India. That reflects commitment and consistency toward national healthcare access.

What differentiates Davaindia from competitors?
Culture. We strongly believe in women empowerment — increasing female workforce participation significantly over recent years.

We also run initiatives like Care for All, supporting injured or abandoned street animals. CSR should not be symbolic; it must be genuine.

Internally, we invest deeply in leadership development through immersive training programs conducted outside traditional office environments to expand thinking and innovation.

What does success look like for Davaindia, and for you personally, in the coming years?
Organisationally, success means ensuring affordable medicines reach every corner of India.

Personally, success means creating happier people around me. My aspiration is that every core team member owns a home soon because roti, kapda, aur makan remain fundamental human needs.

I want to build an organisation that exists for people, not merely for scale or size, and contribute toward building a better world through healthcare, mentoring and leadership.

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INTERVIEW

IVF ecosystem must evolve from being procedure-driven to being evidence-driven

Dr Gautam Daftary, Founder, Chairman and Managing Director, Aksigen IVF in an interaction with Kalyani Sharma, discusses advancements in reproductive medicine, the role of emerging technologies, and the need for greater transparency, scientific rigor, and education in India's rapidly evolving fertility ecosystem

You have been the driving force behind organisations such as Bharat Serums and Vaccines and Aksigen IVF. What key leadership principles have guided you in building and scaling successful healthcare enterprises across diverse segments? Which decisions or experiences have most influenced your approach to innovation and enterprise building?

My experience across Bharat Serums and now Aksigen IVF has reinforced a few fundamental principles about building healthcare institutions. First, innovation in healthcare must always begin with an unmet patient need rather than a market opportunity. At Bharat Serums, our focus on women's health and critical care biologics came from recognizing areas where patients had limited therapeutic options. Second, long-term scientific commitment is essential. Healthcare innovation requires sustained investment in research, manufacturing excellence, and clinical understanding. These are not short-term efforts.

Finally, building institutions requires creating a culture where science, ethics, and patient outcomes remain central to every decision. In healthcare, credibility and trust are built over decades. Those experiences shaped our approach at Aksigen IVF, where we are now focused on translating scientific insight and clinical experience into better patient care.

In healthcare, innovation must begin with an unmet patient need and end with measurable clinical impact.

> One of the consistent challenges in fertility care is that patients often begin treatment without a clear understanding of the biological processes involved. IVF can feel complex and intimidating, and that uncertainty can influence how patients experience and complete treatment

The Bharat Daftary Knowledge Centre is described as India's first immersive fertility centre. What was the idea behind this initiative, and how will it impact education and awareness in reproductive health?

One of the consistent challenges in fertility care is that patients often begin treatment without a clear understanding of the biological processes involved. IVF can feel complex and intimidating, and that uncertainty can influence how patients experience and complete treatment.

The idea behind the Bharat Daftary Knowledge Centre was to create a space where fertility science can be explained in a visual and accessible way. Patients can understand reproductive biology, the causes of infertility, and how different treatment approaches work.

There is a growing body of literature showing that when patients understand their medical condition and treatment pathways, they tend to experience less anxiety and demonstrate better adherence to therapy.

Education therefore becomes an important part of the clinical journey.

At Aksigen IVF, we see the Knowledge Centre not merely as an educational initiative but as an intervention grounded in scientific thinking. Over time, we also intend to contribute to the literature by studying how structured patient education influences treatment experience and outcomes.

Patient education is not just a communication tool; it can be an important component of evidence-based care.

Biologics and hormone therapeutics have been central to your work. What breakthroughs in this area could significantly improve IVF success rates in the coming decade?

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remains one of the most important scientific foundations of fertility treatment. Hormones regulate the ovarian environment, follicular development, and the broader reproductive physiology.

Over the years, advances in recombinant hormones and biologics have already improved the safety and consistency of stimulation protocols. Looking ahead, the next phase of innovation may come from better understanding how individual patients respond to hormonal signals.

As our understanding of metabolic health, endocrine responses, and ovarian reserve improves, we will likely see more individualised stimulation strategies that are tailored to each patient's biological profile.

What role do emerging technologies such as AI, advanced embryo selection, and genomics play in the future of fertility care?
Technologies such as AI, imaging systems, and genomics are expanding our ability to observe and analyse biological processes in greater detail. These tools can provide valuable information to clinicians and embryologists as they make decisions during treatment.

However, technology should be viewed as an enabler rather than the centre of fertility care. Ultimately, fertility treatment remains deeply biological, and the clinician's understanding of reproductive physiology continues to play a critical role.

The most meaningful progress will likely occur where technology and biological insight come together. More specifically, technology adds value when it deepens our understanding of biology.

India's fertility market is growing rapidly. What structural changes are necessary to ensure quality, ethical practice, and long-term sustainability in the sector?
As fertility care expands, maintaining quality and scientific integrity becomes very important. One important step would be greater transparency in outcome reporting so that patients can better understand treatment performance.

Another area is strengthening clinical governance and ensuring that treatment approaches are supported by evidence and careful clinical reasoning.

Finally, greater investment in research and data generation within India would help refine treatment strategies and improve outcomes across the sector.

As the IVF sector grows, it becomes even more important that science and transparency remain at its core.

Do you believe India has the potential to become a global hub for fertility treatments? What gaps still need to be addressed?
India certainly has strong clinical talent and a growing ecosystem of fertility centres. The country also has advantages in terms of cost and accessibility.
However, becoming a global hub requires more than scale. It requires consistent quality standards, strong laboratory systems, and participation in international scientific research.

If we align our clinical strengths with rigorous scientific frameworks, India could play a significant role in global reproductive medicine. India has the clinical talent and infrastructure to become a global fertility hub, provided we align scale with scientific rigor.

Looking ahead to the next decade, what are the biggest scientific and systemic shifts that will redefine IVF globally?
The next decade will likely bring a deeper integration of reproductive endocrinology, genetics, and data science. Fertility medicine is moving toward a model where treatments are more individualized and informed by biological markers.

Rather than one standardised approach, we may see treatment pathways that are tailored to the specific physiological and metabolic characteristics of each patient.

The future of IVF will increasingly be defined by precision medicine and individualised treatment strategies.

What innovations do you believe will have the most meaningful impact on improving accessibility and affordability of fertility treatments?
Improving accessibility requires innovations not only in technology but also in clinical practice. Simplified protocols, better patient selection, and earlier diagnosis can help reduce treatment complexity and cost.

Equally important is improving fertility awareness so that couples seek medical advice earlier, when simpler treatment options may still be possible.

Accessibility in fertility care depends not only on technology but also on smarter and more efficient clinical pathways.

If you could change three things about the current IVF ecosystem in India today, what would they be?
If I had to highlight three areas for improvement, they would be:

1. Greater transparency in outcome reporting.
2. Stronger emphasis on patient education and counselling.
3. Increased research and evidence generation within India.

These steps would strengthen both the credibility and the long-term sustainability of the sector.

The IVF ecosystem must evolve from being procedure-driven to being evidence-driven.

As a pioneer in this field, what advice would you give to the next generation of clinicians and scientists entering reproductive medicine

Reproductive medicine is a fascinating field because it combines endocrinology, genetics, embryology, and clinical care. Young clinicians entering the field should invest time in understanding the biological foundations of fertility rather than focusing only on procedural aspects.

Equally important is maintaining empathy for patients, because infertility can be an emotionally challenging experience.

The future of fertility medicine will be shaped by clinicians who combine scientific rigor with deep empathy for patients.

What is your long-term vision for Aksigen IVF and its role in shaping the future of fertility science in India?
Our long-term vision is to build a fertility institution that contributes to science, education, and patient care simultaneously.

Through initiatives such as the Bharat Daftary Knowledge Centre and our work on structured treatment pathways, we hope to create an environment where fertility care is guided by scientific understanding, transparency, and continuous learning.

Over time, we would also like to contribute to the scientific literature and help strengthen the evidence base for fertility care in India.

Our ambition is to build centres of excellence where fertility care is guided by science and evidence.

INTERVIEW

Senior care represents a significant opportunity in India, estimated to be $14+ billion by 2031

Dr Chirag Adatia, Partner in the Health & Life Sciences and Private Capital Practices at Oliver Wyman, shares insights on India's evolving healthcare landscape. He highlights a shift toward scale, innovation, and more patient-centric, efficient care models, in an exclusive interview with **Lakshmipriya Nair**

What are the structural shifts in healthcare which will matter most over the next decade. Why?
India's healthcare sector is entering a structurally different phase of growth, driven by economic expansion, demographic shifts, and policy interventions. With GDP expected to grow at seven to eight per cent over the coming years, healthcare is likely to grow at nearly 1.5 times that rate. This is largely because India still spends only around four per cent of its GDP on healthcare; as incomes rise, healthcare demand tends to increase disproportionately.

One of the most visible shifts is consolidation across hospitals, diagnostics, and pharma. These segments remain fragmented, and scale is becoming increasingly important to improve clinical outcomes, optimise costs, and attract long-term capital. While brownfield expansion will continue to drive growth, there is likely to be some moderation in valuation expectations, leading to more rational deal-making.

Another important transition is the gradual move from low-cost manufacturing to innovation, particularly in pharma and biotech. Indian companies are beginning to invest in developing their own novel therapies rather than relying solely on reverse engineering. This shift will take time, but the early building blocks for an innovation-led ecosystem are now visible.

> If I were advising an Indian healthcare board today, the single most important decision over the next 12–18 months would be where to place its next cycle of capital, both financial and organisational

Health insurance penetration is also changing the demand landscape. Government-led initiatives such as Ayushman Bharat, including its recent expansion to cover citizens above 70 years of age, have significantly expanded coverage, especially for lower-income groups. This will continue to improve access to organised healthcare.

Finally, demographics will play a critical role. While India remains a young country, the fastest-growing age group is above 55. Longer life expectancy and higher disposable incomes are already driving demand for chronic care and senior care models, which are likely to see sustained growth over the next decade.

Hospitals are increasingly becoming digital platforms, not just physical assets. How should Indian hospital CEOs rethink scale, productivity and margins in this new model?
While hospitals increasingly position themselves as digital platforms, many digital initiatives have been built as "show horses" rather than "work horses." Apps often operate in silos, fail to deliver seamless online-offline journeys, and end up as cost centers instead of drivers of productivity or margins.

For hospital CEOs, digital should be treated as a business lever, not 'tick the box initiative'. The focus must shift to making digital initiatives accountable – both operationally and commercially. E.g., using it to drive measurable improvement in patient experience, build loyalty, enable cross-sell, and allow hospitals to remain connected with patients beyond hospital visits. This does not always require an app; simple, well-integrated tools such as WhatsApp-based or agentic interfaces can often be more effective.

At the same time, hospitals must use digital and data to unlock efficiencies across procurement, operations, and waste reduction. GenAI is already delivering real use cases in healthcare in India, both in front-end engagement and in backend optimisation.

Finally, scale should be redefined beyond beds and occupancy to be partner of choice for family's lifecycle. With hospitals expanding into diagnostics and pharmacies, this will become even more important. While India is still a procedure driven market, as market matures and insurance penetration improves, we would start seeing the move towards community oriented, value-oriented care.

What strategic gap do most Indian hospital groups still ignore?

One area that many Indian hospital groups continue to underestimate is patient experience and loyalty as a long-term value driver. Despite investments in clinical capacity and infrastructure, patient journeys remain fragmented, unpredictable, and opaque. Long wait times, poor information flow, broken handoffs between departments, and limited digital-physical integration continue to erode trust. As patients live longer and engage with healthcare systems more frequently, experience, continuity, and trust will increasingly influence choice and loyalty. Hospitals that fail to invest meaningfully here risk becoming interchangeable service providers.

The second major gap is the underdevelopment of organised secondary care. Over the last decade, growth has been heavily skewed towards tertiary care and single specialty models. Secondary care continues to remain fragmented and largely represented by small nursing homes. This does represent a significant opportunity to build scale, improve access, and create integrated care pathways that feed into higher-acuity centers over time.

India's medtech story is evolving from 'Make in India' to 'Innovate in India'. What capabilities must Indian MedTech firms build to become global category leaders?

Unlike pharma, medtech is a highly consolidated industry dominated by a few large global players. As India's medtech ecosystem moves from "Make in India" to "Innovate in India," global leadership will depend on building a few critical capabilities beyond cost-efficient manufacturing. This needs to be addressed at two levels:

What companies can do:

Most innovation in India today is still centred on commercial models or incremental engineering to lower costs or make minor tweaks. While a few companies have begun innovating in India for global markets, these examples remain limited. To make this shift at scale, companies need three core capabilities. First, true research—not just development—where teams spend as much time in hospitals, operating rooms, and with clinicians and patients as they do in labs and the R&D centers. Second, strong incubation and seeding capabilities to spot promising early-stage innovations globally, including from early stage VCs and universities, and incubate them for scale. And third, long-term innovation funding, with budgets that extend beyond annual financial cycles and take a 5-15 year horizon to impact.

What the government can do:

The government has made meaningful progress over the past four to five years in supporting medtech, but there is scope to go further. Building robust local supplier ecosystems around medtech SEZs is critical, as many components are still imported and only assembled in India. There is also a need to actively incentivise R&D spending—not just for incremental innovation but for breakthrough technologies—through tools such as tax incentives, CSR-linked R&D allowances, or volume guarantees for innovative products. Finally, fostering a university-led innovation culture is essential. Medtech innovation requires close collaboration between medicine, engineering, and industry, but these ecosystems remain siloed in India. Strengthening these linkages can help create a sustainable innovation engine, as globally many of the most impactful breakthroughs originate in universities before being scaled by industry.

Private capital is pouring into healthcare but exits remain selective. What differentiates investable healthcare platforms in India today?

Private capital has been active in Indian healthcare for the last several years, and has delivered strong outcomes. Recent transactions, particularly in segments like hospitals and domestic formulations, show that good quality assets have generated healthy IRRs (even in USD terms) and, in select cases, have gone through multiple rounds of PE ownership. The issue currently is not lack of capital or exits, but scarcity of scalable, well-run assets.

Investable healthcare platforms today are defined by a few clear factors. First, strong fundamentals, sound unit economics, defensible locations, and operational discipline. Second, management quality. Healthcare is execution-heavy, and strong, ethical leadership is critical, especially in minority investments. Third, reputation and trust with doctors and patients, which remain difficult to rebuild once damaged. Finally, evidence of winning in specific micro-markets matters. Healthcare scales city by city, and platforms that dominate a few focused markets or categories give investors' confidence in sustainable growth and exit visibility.

Tier-2 and Tier-3 markets are the next growth frontier. What mistakes do healthcare operators commonly make when expanding beyond metros?

Tier-2 and Tier-3 markets represent a significant growth opportunity, but many healthcare operators stumble on execution. One of the biggest challenges is attracting clinical and managerial talent, though this is gradually easing as living standards, education, and infrastructure in these cities improve.

A common mistake is replicating the metro hospital model without adapting it to local realities. Tier-2 markets differ meaningfully in case of mix, pricing sensitivity, referral behavior, and patient expectations. While rentals may be lower, doctor's salaries and consumable costs are often comparable to metros, making unmodified metro economics unsustainable. Several operators have struggled or pulled back precisely for this reason.

Another frequent misstep is alienating the local clinician ecosystem. Tier-2 cities typically have strong, well-established doctors and referral networks. Successful expansion requires positioning the hospital as a partner that enhances clinical capability, not as a competitor. Finally, creating an "expensive metro hospital" perception through overly plush infrastructure can backfire. In these markets, trust, affordability, and quality of care matter far more than optics, and misjudging this can slow adoption and damage long-term credibility.

Senior care is emerging as a major opportunity. What scalable models can work in India without importing Western cost structures?

Senior care represents a significant opportunity in India, estimated to be $14+ billion by 2031, but scalable models must be built around local social and family dynamics rather than imported frameworks. Several models can scale effectively in the Indian context, and some of them are already in play. Senior living communities are already gaining traction, with both small and large formats offering safe, convenient environments and peer-based social living. Specialised care facilities, for dementia, mental health, short-term recovery, or end-of-life care, can address specific needs without requiring long-term institutionalisation. Health management or concierge models can serve as a "healthcare relationship manager," coordinating outpatient care, reminders, bookings, and navigation across providers. Finally, there is significant whitespace in senior-focused products such as mobility aids, monitoring devices, home-care equipment, and daily living aids, currently dominated by imports with few strong Indian brands, creating an opportunity for cost-effective, locally designed solutions.

If you were advising an Indian healthcare board today, what is the one decision they must get right in the next 12–18 months?

If I were advising an Indian healthcare board today, the single most important decision over the next 12–18 months would be where to place its next cycle of capital, both financial and organisational. This means making deliberate choices on three fronts.

First, investing ahead of the curve in innovation. For pharma and medtech, this would be developing innovative product pipeline through a combination of sourcing, partnering and developing. For providers, this would be about pushing the boundaries on care delivery models, digital capabilities, and clinical offerings, to avoid being disrupted rather than leading changes.

Second, committing meaningfully to patient experience, which will increasingly drive word-of-mouth, repeat engagement, and even clinician loyalty. This remains under-invested but will emerge as a truly competitive differentiator.

Lastly, boards must prioritise operational efficiency to create "dry powder"—freeing up capital through better productivity and cost discipline. This liquidity will be critical to fund acquisitions and growth opportunities as consolidation accelerates across the sector.

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Why most Indians with hemophilia still lack access to standard of care

Dr Chandrakala S, Consultant in Haematology, Haemato-Oncology and BMT, Sparsh Hospital, Hennur, Bangalore, highlights that hemophilia is far more than a rare bleeding disorder—it is a lifelong, inherited condition that significantly impacts patients from early childhood

Hemophilia is not merely a rare disorder — it is a lifelong, inherited bleeding condition in which the blood fails to clot properly leading to spontaneous bleeding presenting early in life. India carries the second largest hemophilia burden in the world — yet for many patients, access to lifesaving care remains uncertain..

Hemophilia A is most common with an incidence of 1 in 10,000 births and it is due to deficiency of FVIII, they account for the majority of the cases seen in clinical practice.

The hallmark presentation hemophilia is hemarthrosis, most frequently affecting the weight bearing joints such as knee, ankles and elbow. Other clinical presentations are bleeding in muscles mainly in psoas, calf and thigh muscles, occasionally they can have life-threatening bleeding such as bleeding in the brain. Recurrent joint bleeding damages the lining of the joint cavity, cartilage and then bone leading to chronic pain, deformity and permanent disability.

Hemophilia treatment primarily consists of replacing the missing coagulation factor through clotting factor concentrates. There are two types of treatment in hemophilia - On demand therapy given at the time of acute bleed which will not change the natural course of disease. Prophylaxis in which PWH receives regular infusion of clotting factor concentrates or non factor therapy to prevent the bleeding and joint damage. Prophylaxis is the standard of care recommended by the World Federation of Hemophilia. Prophylaxis reduces the bleeding rates by almost 80 to 90 per cent and preserves joint function.

Globally, 70-90 per cent of patients in developed healthcare systems receive prophylaxis as standard of care. In India, only 4-5% of the patients are on prophylaxis which is slowly increasing. This is due to many reasons such as lack of awareness, accessibility, lack of sustained supply of drugs and affordability. Without access to prophylaxis, thousands of Indian children are denied the chance of a bleed-free childhood and an adulthood free from preventable disability.

Hemophilia treatment primarily consists of replacing the missing coagulation factor through clotting factor concentrates. There are two types of treatment in hemophilia - On demand therapy given at the time of acute bleed which will not change the natural course of disease

Early diagnosis and starting prophylaxis is the single most critical determinant of long-term prognosis. In many parts of the country, particularly in rural and semi-urban regions, access to specialised coagulation testing and factor assays is limited.

This has resulted in children often being misdiagnosed with orthopedic injuries, vitamin deficiencies, or "normal bruising," delaying appropriate action and intervention. Under-diagnosis continues to be a significant concern, which means the true burden of hemophilia in India is likely far greater than what reported figures suggest.

For those diagnosed accurately, access to comprehensive Hemophilia Treatment Centres (HTCs) is limited. While metropolitan cities could offer structured care with trained hematologists or trained doctors along with physiotherapy support, patients in far-flung districts frequently travel long distances sometimes across states to receive treatment. This geographic bias translates into delayed infusions, episodic rather than preventive care, and needless complications.

In a condition where time-sensitive intervention makes a key difference between a preserved joint and irreversible injury, distance and limited access can have serious consequences. The socioeconomic toll is equally profound and often invisible. Recurrent joint bleeds disrupt schooling, impact confidence and participation in physical activities. Many children grow up adopting the fear of spontaneous bleeds, leading to social withdrawal and restricting their life aspirations. For adults, recurring hospital visits and recovery periods translate into lost workdays, diminished productivity, and in many cases, job instability. Families have to account for the direct costs of travel and supportive care, along with the psychological burden of constant care, having to plan life around the possibility of the next bleed.

Hemophilia, therefore, is not simply a medical condition; it is a chronic socio-economic burden that affects education, employment, mobility, and mental well-being of individuals.

Until gaps in screening, diagnosis, infrastructure, and equitable access to prophylaxis are addressed, India's hemophilia community will continue to face a reality where modern science exists but remains frustratingly out of reach.

The standard of care is regular prophylaxis, that means infusions of clotting factors to prevent spontaneous bleeds in a scheduled manner rather than treating it after they occur. Prophylaxis has shown proven results in reducing joint damage, lesser number of hospitalizations, prevention of long-term disability and overall efficiency in healthcare system costs.

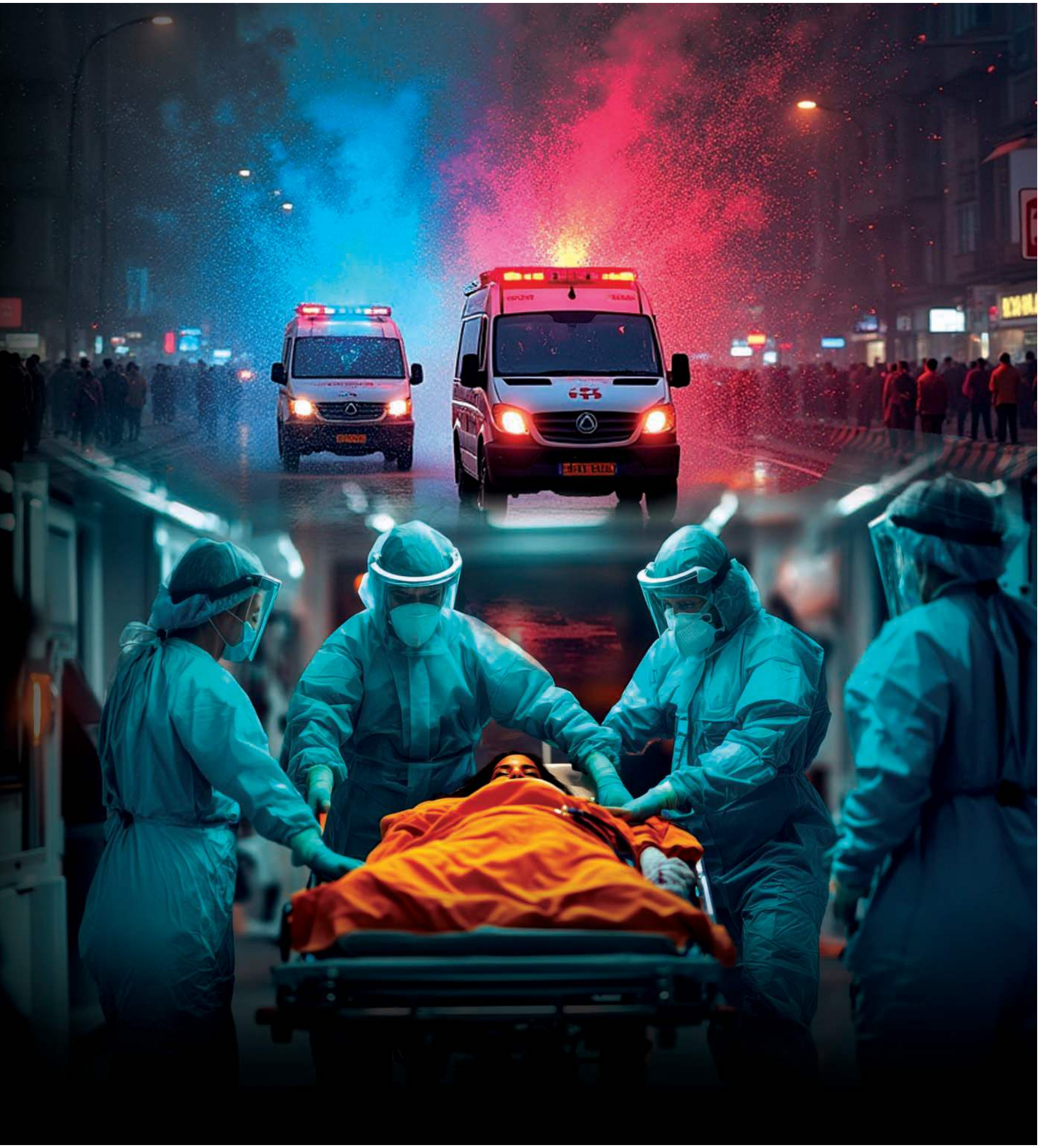
However, consistent access to prophylaxis is not extensively available across the country.

Innovations in treating Hemophilia have rapidly grown across the globe. While extended half-life products and non-factor therapies like Emicizumab have profoundly reshaped lives in Hemophilia A, ensuring even access to these transformative treatments remains an ongoing journey. Hemophilia care in India is supported under National Health Mission (NHM) framework, with several States providing free clotting factor concentrates and non factor therapies such as emicizumab through Government- funded programs at designated Hemophilia Treatment Centres. Under these State-backed initiatives, patients are enabled to receive factor replacement therapy without direct cost. This shows a significant policy commitment toward even-handed access. Despite policy advances, uneven execution, variable infrastructure, and disparities in resource allocation across states continue to hinder the delivery of consistent, standard- of-care treatment across the country.

FROM SIRENS TO SYSTEMS
REIMAGINING EMERGENCY CARE IN INDIA

As rising urban pressures, disease burdens, and climate-linked crises test response systems, the next leap will depend on how well India integrates technology, infrastructure, and policy into a unified, patient-centric emergency network

Kalyani Sharma



India's emergency care landscape is undergoing a fundamental shift from episodic, hospital-based intervention to a continuous, system-driven response.

As Dr Sarbari Swaika, Professor and HOD-Department of Emergency Medicine, DPU Super Specialty Hospital, Pune explains, "Emergency care in India is undergoing a profound transformation. Traditionally perceived as a hospital-based, reactive service confined to the "casualty," it is now evolving into a dynamic, system-oriented discipline that emphasises timeliness, coordination, and continuity of care."

This shift is visible on the ground. Pre-hospital care is gaining strength, and early intervention is becoming critical.

Dr Himanshu Dewan, Group Director-Critical Care Medicine, Sarvodaya Healthcare highlights how this transformation is already saving time and lives, "Emergency care is becoming more proactive, rather than merely reactive. Currently, emergency units have resources like ventilators and other advanced machines at their disposal with the added support of well-organised emergency medicine staff. Through technology, there is a more efficient collaboration between hospital emergency rooms and pre-hospital emergency personnel. For example, an ambulance technicain can send an ECG of an heart attack patient or convey the symptoms suggestive of stroke to emergency and they can start the treatment at pre hospital level (on the way to hospital) saving crucial time."

The emphasis is no longer just on treatment but on when and how quickly it begins.

The role of hospitals as central anchors in emergency response is also gaining prominence.

Urvaksh Bhote, COO, Ruby Hall Clinic explains, "Hospitals are evolving beyond passive care centres into active emergency response hubs. Large institutions are integrating advanced emergency departments with triage systems, critical care units, and dedicated trauma protocols. This hospital-centric approach ensures that once a patient reaches the facility, diagnosis and intervention begin immediately reducing mortality in critical cases like cardiac events, strokes, or trauma."

This underscores a critical shift—while technology and logistics are expanding the ecosystem, hospitals continue to remain the core nodes where definitive care is delivered.

Many emergencies are not identified or acted upon quickly enough, which leads to lost critical time even before the system is activated

Satish Kumar Singh
Founder,
MY LYF CARE

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The ecosystem challenge: Fragmentation and inequity

Despite this evolution, India's emergency response system remains fragmented.

Gaurav Karambelkar, Senior Manager-IEC, Sumeet SSG underscores the core issue. He highlights, "The biggest gap is not having a cohesive emergency response ecosystem at all. We have various individual emergency care programs running simultaneously throughout the country – which are doing an adequate job, no doubt – but all of them operate in their own individual silos. A comprehensive, cohesive national framework is urgently required. Uneven geographical coverage is another big gap. While urban areas have multiple avenues of emergency care, rural and semi-urban areas face significant deficits in timely access, not to mention availability of required resources."

This fragmentation is compounded by access disparities. Dr Saifa M. Latheef, Associate Professor & Clinical Head, Emergency Medicine, Sharda Care Healthcity points out, "Inequality in access despite improvement is still a critical issue especially between the urban and rural areas. There are also numerous regions which do not have trained emergency responders, and

communication between ambulances, hospitals and authorities is not always smooth. The other issue is that standardised protocols do not exist across states. These gaps can be considerably addressed through the implementation of stronger training programs of the paramedics, better infrastructure development in the tier-2 and tier-3 cities and the creation of a more interconnected emergency response network. Education of the masses on the need to identify emergencies and obtain immediate assistance is also significant."

Even where infrastructure exists, coordination gaps persist. Dr Krishna Prasad Rao Vunnam, Founder and Managing Director, Ankura Hospital notes," One of the biggest challenges is the lack of an integrated emergency system, with fragmented coordination between ambulances, hospitals, and call centres. This often leads to delays, duplication, and confusion in patient transfers."

A city-level view further reinforces these systemic gaps. As Bhote observes, "The biggest bottlenecks in Pune's emergency response remain traffic congestion, inconsistent ambulance response times, and lack of a unified command system connecting hospitals in real time. Often, patients or ambulances move from one hospital to another due to bed unavailability or lack of specialised care, leading to critical delays."

His observation highlights how fragmentation plays out in real-world scenarios—especially in dense urban environments where infrastructure exists but coordination lags.

In effect, the system is only as strong as its weakest link and today, those links are often disconnected.

Technology as a catalyst: Faster, smarter, predictive

Technology is emerging as the strongest enabler of this transformation.

Dr Ashish Chandra, Chief Operating Officer, ISIC Multispeciality Hospital highlights the role of advanced tools, "Artificial intelligence can support rapid triage and predictive analytics, helping responders prioritise cases more effectively."

From connected ambulances to wearable devices, the system is becoming increasingly data-driven.

Dr (Col) Suvasish Chakraberty, Chief-Emergency, Artemis Hospitals explains, "Emergency care will change thanks to technologies like AI, real-time GPS tracking, telemedicine and health devices that you can wear. These new ideas will make emergency response faster, more data-driven and easier to get to in different areas."

We have various individual emergency care programs running simultaneously throughout the country – which are doing an adequate job, no doubt but all of them operate in their own individual silos

Gaurav Karambelkar
Senior Manager-IEC,
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Founder and Managing Director,
Ankura Hospital

While technology and logistics are expanding the ecosystem, hospitals continue to remain the core nodes where definitive care is delivered

At the same time, integration remains key. As Dr Vunnam notes, "Connected ambulances, equipped with telemedicine and live data-sharing capabilities, will increase, enabling hospitals to begin intervention even before the patient arrives."

The direction is clear: emergency care is moving from reactive response to predictive, coordinated action.

Quick-commerce: Disruptor or enabler?

A new and unexpected player has entered the emergency ecosystem—quick-commerce.

These platforms promise rapid delivery of medicines and medical essentials, particularly in urban areas.

Dr Chandra sees their potential, "Quick-commerce and hyperlocal delivery platforms can play a valuable supplementary role in emergency care, particularly in bridging last-mile gaps. These platforms can enable rapid delivery of essential medicines, medical devices, or first-aid kits during emergencies, especially in congested urban settings. Importantly, these platforms should complement—not replace—formal emergency systems, functioning as an auxiliary support layer that improves accessibility and speed without compromising clinical oversight."

However, experts are cautious about their role.

Satish Kumar Singh, Founder, MY LYF CARE draws a clear boundary, "These platforms have the potential to significantly enhance emergency response, but their role must be clearly defined. They should function as a last-mile logistics layer, not as clinical decision-makers."

Similarly, Dr Dewan stresses the limits of logistics. He stresses, "Difficult to draw useful inference from e-commerce as these platforms provide objects in a short time, and healthcare needs to provide expertise at the point of need, with time as a crucial factor."

The consensus is clear—quick commerce can support

emergency care, but not substitute it. Integration with clinical systems and strict regulatory oversight will be critical.

Persistent bottlenecks: Time lost is life lost

Even as innovation accelerates, several bottlenecks continue to hinder emergency response.

Traffic congestion remains a major barrier. Dr Latheef notes, "Traffic jam, absence of synchronised communication systems, and shortage of trained manpower are some of the factors that usually lead to delays in emergency care. Ambulances in most occasions have trouble beating traffic jams and this means that it wastes vital time."

Communication gaps further slow the system. Dr (Col) Chakraberty highlights, "Emergency services don't respond as quickly when they can't talk to each other."

Workforce shortages are another critical concern. As Dr Dewan points out, "This gap is further increased by lack of trained emergency professional and structured healthcare facilities."

In many cases, delays begin even before the system is activated. Singh observes, "One of the most underestimated bottlenecks is delayed incident recognition. Many emergencies are not identified or acted upon quickly enough, which leads to lost critical time even before the system is activated."

Quick-commerce and hyperlocal delivery platforms should complement and not replace formal emergency systems, functioning as an auxiliary support layer that improves accessibility and speed without compromising clinical oversight

Dr Ashish Chandra
Chief Operating Officer,
ISIC Multispeciality Hospital

Emergency services don't respond as quickly when they can't talk to each other

Dr (Col) Suvasish Chakraberty
Chief-Emergency,
Artemis Hospitals

These challenges underline a simple truth: speed in emergency care depends as much on systems as on infrastructure.

The integration imperative: Towards a unified national framework

There is near-universal agreement among experts on one key solution—a unified, integrated emergency response system.

Dr Chakraberty emphasises the need clearly, "India really needs a single national emergency response plan to make sure that things happen quickly and consistently across the country."

Karambelkar reinforces this with a global perspective, "India would benefit significantly from a unified and interoperable national emergency response framework along the lines of 911 in the USA, 999 in the UK, 112 in the EU, 000 in Australia."

Public–private partnerships will be central to building this ecosystem. Dr Vunnam notes, "The public sector can provide policy direction, standardisation, and scale, while the private sector can bring in technology, innovation, infrastructure, and operational efficiency."

The goal is not just integration but seamless coordination across every stage of emergency care.

The road ahead: Building a resilient, responsive system

India stands at a critical juncture in its emergency care journey.

The vision, as Dr Swaika articulates, is clear, "Emergency care in India is being redefined not merely as a service, but as a time-sensitive, system-integrated, and outcome-oriented domain of healthcare."

Achieving this vision will require sustained investment in infrastructure, workforce training, technology, and governance. It will also demand a shift in mindset, recognising emergency care as a foundational pillar of the healthcare system.

Because ultimately, in emergency medicine, every minute matters and every improvement in response can mean the difference between life and death.

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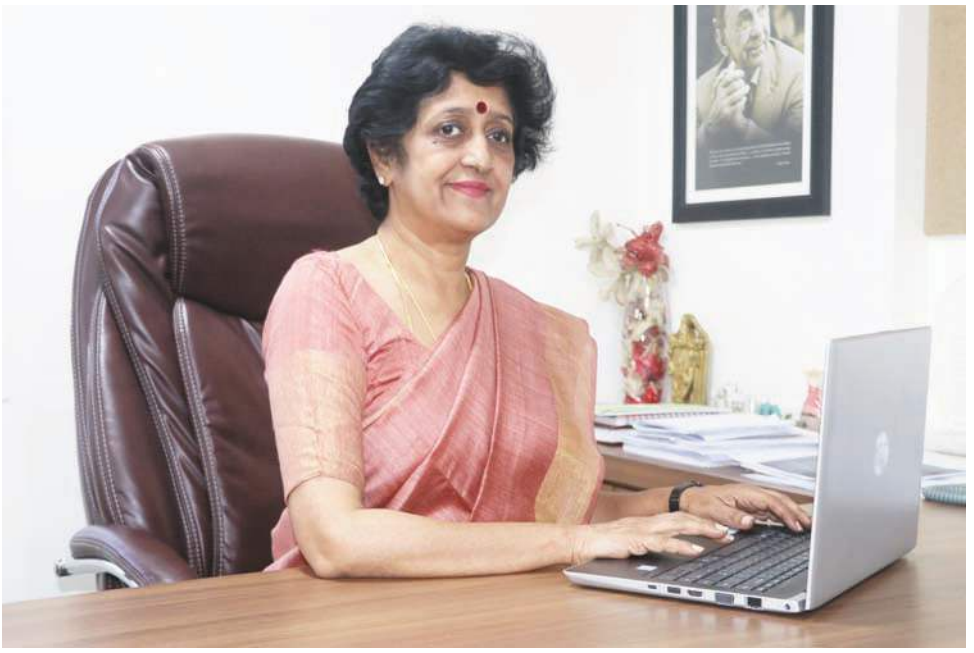
INTERVIEW

Emergency room as a 'mini hospital within the hospital'

Fortis Hospital, Mulund recently launched its next-generation Emergency Medicine Department (ER). **Dr S Narayani,** Business Head, Fortis Hospitals, in an interview with **Kalyani Sharma,** discusses the evolving role of emergency care and the concept of the 'New-age ER'

You described the emergency room as a "mini hospital within the hospital." Could you elaborate on what this concept means in practice and how it transforms emergency care delivery?
When we describe the Emergency Room as a "mini hospital within the hospital," we mean that it is designed to function as a fully integrated care unit, capable of delivering comprehensive medical services any time, especially when routine services may not be operational. A hospital typically functions like an orchestra, with multiple departments such as OPD, diagnostics, specialty services which work together to offer care to patients. However, illness does not follow a schedule. Patients don't choose when they fall sick. It happens at night, on holidays, or when key departments aren't running. And in those moments, the biggest challenge isn't always the illness — it's the uncertainty. Is this serious? Can it wait? Should I rush to the emergency room?

As healthcare providers, we have a responsibility to close that gap. Access to clear guidance, responsive support, and reassurance, especially outside regular hours, isn't a luxury, it's essential. When patients know someone is available to guide them, even briefly, it builds trust. Our Emergency Room (ER) bridges this gap. It provides immediate access to consultations, diagnostic support, and multidisciplinary care under one roof – defining strong healthcare systems. From minor concerns requiring evaluation to complex, critical, life-saving interventions, the ER is equipped to manage the entire spectrum. Importantly, patients do not need to decide the severity of their condition before seeking help. The ER ensures timely assessment, stabilizes and treats patients as needed, and either discharges them safely or transitions them to appropriate inpatient or specialist care. Once stabilised, patients can seamlessly return to their primary physician for continuity of care. Hence, the ER transforms emergency care delivery by ensuring that no patient ever feels uncertain about where to go - day or night.



What inspired the decision to launch the 'New-age ER' and how does it reflect the evolving healthcare needs of the community? How do you define success for the 'New-age ER'?
The decision to launch the 'New-age ER' was driven by the evolving understanding that emergency care is not merely about stabilising a patient and transferring them elsewhere; it is about delivering definitive, time-sensitive treatment from the very first minute. Traditionally, Emergency Rooms functioned as triage and stabilisation units, with patients quickly handed over to critical care or specialty departments. However, modern medicine has demonstrated that outcomes in conditions such as heart attacks, strokes, severe trauma, and sepsis are directly linked to how quickly comprehensive treatment begins. Saving myocardium in a cardiac event, reversing neurological damage in a stroke, or preventing deterioration after major trauma depends on interventions delivered within the "golden minutes." The 'New-age ER' reflects this shift. It is built around highly trained, cross-functional emergency physicians and teams who can work seamlessly across specialties. It is supported by advanced point-of-care diagnostics that enable rapid decision-making at the bedside. This integration ensures instant diagnosis and immediate initiation of the correct treatment, rather than delays caused by inter-departmental transfers.

Therefore, the 'New-age ER' is a reimagined, integrated model that packages expertise, diagnostics, and critical interventions into a single, responsive unit designed for today's healthcare demands. We define success for the 'New-age ER' through measurable clinical outcomes reduced door-to-treatment times, improved survival rates, faster recovery, and better long-term prognosis. Equally important is patient confidence: knowing that at any hour, they have access to timely, expert, and comprehensive emergency care under one roof.

Building and sustaining a high-acuity, protocol-driven emergency ecosystem requires significant investment in technology, manpower, and training. From an administrative standpoint, what were the biggest challenges in executing this transformation, and how did you align teams across departments to make the vision a reality?
Building a high-acuity, protocol-driven emergency ecosystem requires simultaneous investment in people and technology, coupled with continuous training. Each of which is

equally critical. It is difficult to single out one as the biggest challenge, because sustainable transformation happens only when all three evolve together. From an administrative standpoint, the first priority was assembling a skilled team with a shared vision and the passion to deliver high-quality emergency care. This meant not only recruiting trained emergency physicians and nurses, but also committing to ongoing upskilling and simulation-based training to keep pace with advancements in emergency medicine. The second pillar was technology. We had to make deliberate, outcome-driven decisions about investing particularly in advanced monitoring systems, point-of-care diagnostics, and protocol-based workflows. Clarity about the clinical outcomes we wanted to achieve helped guide these investments.

Equally important was cross-departmental alignment. Emergency care does not function in isolation. We worked to create strong integration between the ER, critical care, cardiology, neurology, trauma services, diagnostics, and support teams. Clear protocols, defined escalation pathways, and shared accountability ensured that every department understood its role in delivering time-sensitive care. Importantly, this transformation was not a one-time initiative. Our journey began over a decade ago with the establishment of structured emergency medicine services, and we have continuously upgraded our systems in response to evolving medical standards and community needs. The 'New-age ER' is not a destination - it is part of an ongoing commitment to continuous improvement.

Looking ahead, do you see the 'New-age ER' model becoming the standard blueprint for ER departments across India? What future enhancements are you envisioning?

Given this trajectory, the 'New-age ER' model is very likely to become the standard blueprint across India. As awareness grows and healthcare expectations rise, communities will increasingly demand faster, integrated, and outcome-focused emergency care. Hospitals will need to respond with systems that prioritize speed, expertise, and seamless coordination.

Looking ahead, one of the key enhancements we envision is stronger integration with expert ambulance and pre-hospital care services. The future of emergency care lies in creating a continuum from the moment a patient experiences distress at home or on the road, through ambulance stabilisation, ER intervention, critical care, and ultimately recovery. Real-time data sharing, advanced pre-hospital triage, and tighter coordination between field teams and hospital specialists will further strengthen outcomes.

Therefore, the 'New-age ER' is not just about upgrading infrastructure it is about building a seamless, end-to-end emergency response ecosystem that ensures no patient loses precious time at any stage of care.

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Gaps in India's emergency response ecosystem

Aditya Kohli, CFO and Director, Allied Medical Limited, underscores the urgent need to reimagine India's emergency care ecosystem, arguing that true preparedness begins well before hospital doors and hinges on stronger prehospital response, integrated systems, and technology-led coordination to save lives during the critical golden hour

India's healthcare has made commendable strides in expanding the quality and spread of access. You walk into a hospital today, and everything from the infrastructure to the care is miles ahead of what it was before. However, when put side by side with real-time emergencies, something seems amiss.

Contrary to popular belief, emergency response begins before the victim reaches the hospital. In fact, many lives are lost during the golden hour–the first 60 minutes after the event. Filling this with quality solutions will skyrocket the chances of survival.

The current gaps are dominated by prehospital care shortcomings. Low number of ambulances, fewer emergency care providers and low localised preparedness; all play their part in it. Addressing these deficiencies

requires not incremental adjustments, but a deliberate, ethically grounded reimagination of how emergency care is orchestrated.

For instance, in the event of a cardiac arrest, the nearest person must know how to initiate CPR and call for an AED (Automated External Defibrillator). The latter is designed keeping the layman in mind. It will provide all the necessary instructions, along with determining and administering a mild shock to the heart if needed. The aim is to stabilise the victim till the ambulance comes along.

The current network of ambulances is siloed. Without a unified national emergency medical services (EMS) grid, ambulances often work without a GPS or connected technology. A 5G-equipped system allows ER doctors to assess the patient in transit, keep an eye on critical deviations and help them prep according to the situation.

The next natural gap is the readiness of emergency departments. Factors like overcrowding, limited ICU beds and equipment can hinder a process where every second matters. An investment in connected monitoring systems and automated alert mechanisms can help to build scalable designs that are equipped to handle surges.

Technology is not a panacea, but it is undeniably a force multiplier. Latest advancements in artificial intelligence, connected medical devices and predictive analysis can reform the current system to one that's anticipatory. Emergency care has always been a coordinated approach. Systems that respond within minutes can save countless lives, and that's what a country of our stature must aim for.

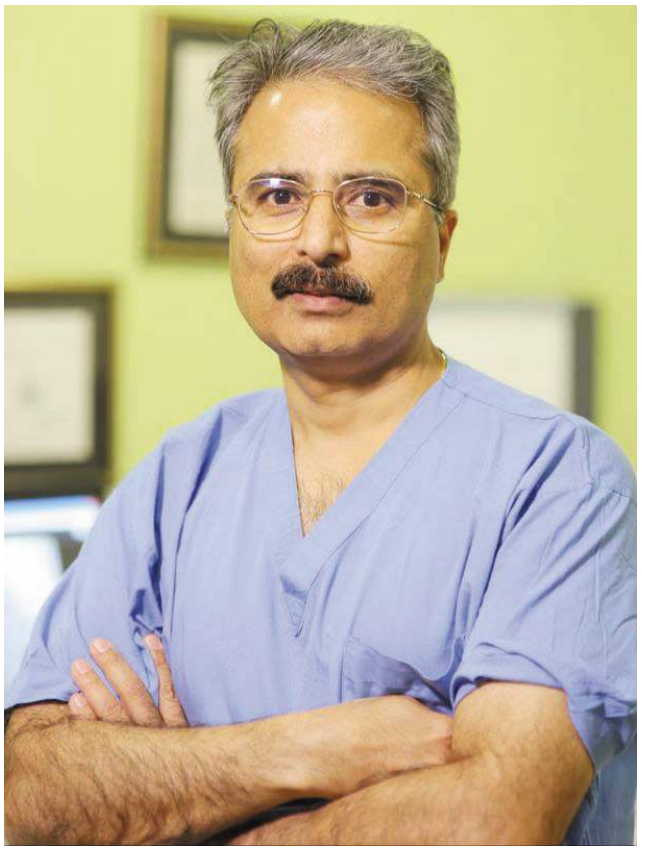
Seeing the unseen: OCT and the future of coronary interventions in India

Dr Rajneesh Kapoor, Chairman, Interventional Cardiology, Medanta Hospital, reflects on the evolving role of imaging in coronary interventions, arguing that while angiography remains foundational, it often falls short of revealing the full complexity of coronary artery disease

As interventional cardiologists, we have long relied on coronary angiography as the cornerstone of diagnosing and treating coronary artery disease. It has served us well, offering a roadmap of the coronary arteries, helping us identify blockages, and guiding interventions. Yet, over time, it has become increasingly clear that angiography, for all its strengths, shows us only a silhouette. It outlines the lumen of the vessel but leaves much of the vessel wall where the true story often lies hidden from view.

In daily practice, this limitation is not just theoretical. We encounter patients whose symptoms seem disproportionate to angiographic findings, or cases where the cause of an acute coronary event is not immediately obvious. These moments remind us that coronary artery disease is more than just narrowing; it is a complex, dynamic process occurring within the vessel wall. This is where Optical Coherence Tomography (OCT) has begun to reshape our understanding.

OCT offers a level of detail that feels almost intuitive once experienced. By producing high-resolution, cross-sectional images of coronary arteries, it allows us to visualise structures that were previously beyond our reach in the catheterisation laboratory. The layers of the vessel wall, the characteristics of plaques, and the interaction between stents and the artery become clearer, enabling a more nuanced approach to intervention.



OCT offers a level of detail that feels almost intuitive once experienced. By producing high-resolution, cross-sectional images of coronary arteries, it allows us to visualise structures that were previously beyond our reach in the catheterisation laboratory

From a procedural standpoint, OCT has introduced a new level of precision. When planning an intervention, it helps us better understand the morphology of a lesion, whether it is fibrous, calcified, or lipid-rich, and tailor our strategy accordingly. This influences decisions around lesion preparation, device selection, and stent sizing. Rather than relying solely on estimation, we are guided by direct visualisation, which brings a greater sense of confidence to each step.

Equally important is the role of OCT after stent deployment. Achieving an optimal result is not just about placing a stent across a blockage; it is about ensuring that the stent is well-expanded, properly apposed to the vessel wall, and free from complications such as edge dissections or residual plaque burden. OCT allows us to assess these factors in detail, often revealing findings that may not be apparent on angiography alone. This ability to refine our results in real time aligns closely with the goal of delivering durable and safe outcomes for patients.

One of the most compelling aspects of OCT is its ability to shed light on mechanisms of acute coronary syndromes. There are instances where patients present with clear clinical signs of a heart attack, yet angiography does not reveal a significant obstruction. In such scenarios, OCT can help identify underlying causes such as plaque disruption, erosion, or other subtle abnormalities within the vessel wall. This deeper understanding can influence how we approach both immediate management and longer-term care.

In the Indian context, the adoption of OCT reflects a broader evolution in cardiovascular care. Over the years, we have witnessed remarkable growth in infrastructure, expertise, and access to advanced therapies. As this landscape matures, there is a natural shift toward tools that enhance precision and individualisation of treatment. OCT fits well within this trajectory, supporting a move from a one-size-fits-all approach to more tailored interventions.

However, the integration of OCT into routine practice is not without its considerations. It requires familiarity with image interpretation, thoughtful case selection, and an understanding of how best to incorporate its insights into clinical decision-making. Like any technology, its value lies not just in its capabilities, but in how effectively it is used. As clinicians, this calls for continuous learning and adaptation.

Beyond the technical aspects, OCT represents a subtle but important philosophical shift in how we think about coronary interventions. It encourages us to look beyond what is immediately visible and to question whether we are addressing the underlying disease process as comprehensively as possible. It moves us from treating what appears to be the problem to understanding what truly the problem is.

Looking ahead, the role of OCT in India is likely to expand as awareness grows and more centres gain access to the technology. Its integration with other modalities and its use in complex cases may further enhance its relevance. At the same time, it will be important to ensure that its adoption is guided by thoughtful clinical judgment, keeping patient care at the centre of every decision.

In many ways, OCT allows us to "see the unseen." It bridges the gap between anatomy and pathology, between assumption and understanding. For those of us in the catheterisation laboratory, it offers not just clearer images, but clearer insights. And in a field where precision can make a profound difference, that clarity is invaluable.

Grey matters: The new old age

India's demographic dividend is set to age into a new reality. How its care ecosystem evolves alongside is a story still unfolding, writes **Neha Aathavale**

India's ambition of becoming a Viksit Bharat by 2047 rests on building strength across sectors. Much of which is powered by its young workforce, often seen as the engine of growth and productivity. But every engine runs on time as much as fuel. The same workforce driving this ambition today will, in the coming decades, transition into an ageing population with very different healthcare needs. The question, then, is not just how India builds for growth, but how it prepares to sustain it.

In numbers, by 2050, India's population aged 60 and above is expected to reach nearly 347 million, accounting for close to one-fifth of the total population, according to the United Nations Population Fund. This shift signals a fundamental change in the kind of care infrastructure the country will require, moving from episodic treatment to long-term, continuous support.

India is preparing to become a younger success story that will eventually need to support an older reality. The transition is gradual, but its implications are clear. Whether the country's healthcare ecosystem is anticipating this shift, or will respond to it as it unfolds, is a question that now deserves closer attention.

India's healthcare infrastructure is evolving to respond to the needs of its ageing population, but preparedness for long-term elderly care remains uneven across regions and service segments

Nilachal Mishra
Partner and Head, Government & Public Services, KPMG India

India's healthcare infrastructure remains inadequately prepared to support the long-term care (LTC) needs of a rapidly ageing population

Rohit Anand
Director – Research & Analysis, Medical Devices at GlobalData

Models that rely less on physical infrastructure and more on distributed care, including home-based services, may be better suited to bridge these gaps

Gaurav Dubey
Founder and CEO, Livlong 365

Built in parts, not as a whole

India's elderly care infrastructure is coming together, but more in pieces than as a system. Senior living communities, assisted care facilities, and home-based services are all expanding, yet largely along separate tracks. The result is an ecosystem that exists, but does not always connect. As Nilachal Mishra, Partner and Head, Government & Public Services, KPMG India notes, "preparedness for long-term elderly care remains uneven across regions and service segments," even as demand is set to rise sharply in the coming decades.

This unevenness is not just structural, but also systemic. While India has expanded access to primary and acute healthcare, long-term care continues to evolve at the margins. As Rohit Anand, Director – Research & Analysis, Medical Devices at GlobalData puts it, the current system is "primarily designed for short-term medical treatment" and does not adequately address "continuous, long-duration care needs associated with ageing." The gap, then, is not just capacity, but intent.

This fragmentation becomes most visible in how care is delivered. For a population that requires continuity, support still tends to be episodic and often anchored around hospital visits. As Dr Ritu Rana, Mission Head – Healthcare, HelpAge India, puts it, "elderly care requires ongoing management of chronic conditions, including functional decline and psychosocial needs, that is close to their home." The gap, then, is not just capacity, but design.

From the housing side, the shift is already underway. According to Ankur Gupta, Joint MD, Ashiana Housing; Senior living demand is "no longer driven by compulsion" but by the need for safety, social connection, and access to care. That shift in intent matters. It signals that elderly care is slowly moving out of the margins and into mainstream consumption behaviour.

Yet, the supply side has not fully caught up. The organised market itself remains small relative to the scale of the need. Estimates suggest that India's senior living and long-term care market is still at a nascent stage with low penetration, even as it is expected to grow steadily over the next decade. Much of this supply remains concentrated in urban pockets, while a large share of India's ageing population continues to reside outside metros.

What emerges is a familiar imbalance. Demand is rising,

but infrastructure is limited, fragmented, and unevenly distributed. As Anand points out, long-term care in India still "relies heavily on family-based arrangements rather than structured, facility-based and professionally managed care services," underscoring the absence of a scalable system.

What is emerging, therefore, is not a fully built ecosystem, but a set of responses trying to keep pace with a changing reality. The pieces are falling into place, but not yet into alignment.

So if the system is still assembling itself, the real story lies in who is stepping in to build the missing pieces.

Emergence of a new care economy

If the need for elderly care infrastructure is becoming clearer, the responsibility of building it is still being negotiated. With limited public provisioning for long-term care, much of the momentum is coming from private players, each approaching the opportunity from a different lens.

For real estate developers, this shift is pushing the boundaries of what housing traditionally meant. Senior living is no longer just about creating age-friendly spaces, but about building environments where care is embedded into everyday life. As Gupta explains, one of the biggest gaps in the current ecosystem is "the lack of integrated environments that combine housing with professional, continuous care." He adds that seniors today are often navigating fragmented systems, "living separately, accessing healthcare externally, and relying on unstructured caregiving support."

This has led to a new kind of collaboration, where developers are partnering with specialised care providers to bridge that gap. The idea is not just to co-locate services, but to create a more seamless continuum where medical support, assisted living, and community engagement exist within the same ecosystem. Models like these are attempting to solve for multiple layers at once, from chronic disease management and post-hospital recovery to day-to-day assisted living.

But building such integrated environments is not straightforward. Gupta points out that senior living is "not just a real estate product, it is an ongoing service ecosystem." Designing these spaces requires anticipating how needs evolve over time, while operations demand consistent caregiving quality, trained manpower, and healthcare integration, challenges that go far beyond conventional residential management.

Alongside developers, healthcare providers and home-care platforms are also stepping into this space, often extending their role beyond hospitals. The shift is being driven as much by necessity as by opportunity. As Dr Rana notes, traditional systems are not equipped to manage "multi-morbidity and other age-related conditions" in a continuous manner, which is pushing both providers and families to look for alternatives that offer greater consistency of care.

This is where home healthcare and technology-enabled platforms are beginning to carve out a distinct role. By bringing services closer to where patients live, they are attempting to address not just clinical needs, but also the logistical and emotional realities of ageing. In many ways, they are filling the gaps left by institutional infrastructure, even as that infrastructure continues to evolve.

What is taking shape, then, is less a single model and more a multi-player ecosystem, where developers, healthcare providers, and specialised eldercare companies are each building different parts of the same puzzle. The challenge will be whether these pieces can eventually come together as a coherent system, or continue to function as parallel solutions.

Because even as new models emerge, where they are being built may matter just as much as how they are being built.

Ageing across pin codes

As infrastructure is still taking shape, its distribution tells a more uneven story. The gap between where seniors live and where formal care is available continues to shape access.

As Mishra states; "India's ageing is not a metropolitan phenomenon. A large part of it is unfolding in smaller towns and rural areas, where formal care infrastructure is either limited or missing." This imbalance creates a situation where demand exists, but does not translate into organised consumption simply because options are absent.

This creates a structural mismatch. Demand is not confined to metros, but supply largely is. As Gupta observes that, locations beyond major cities already show strong underlying demand drivers, including familiarity, lower cost of living, and proximity to existing social networks. In many cases, these are the very places where seniors would prefer to age. Yet, access to formal care infrastructure in such regions remains limited.

From an industry standpoint, this misalignment is becoming harder to ignore. Anand points out, "the question is not just how much infrastructure we build, but where we build it. If supply continues to cluster in urban pockets, it will not address the larger need." His observation underscores a key constraint. Expansion without distribution risks leaving the core problem untouched.

At the same time, the weight of this gap often falls on families. As Neha Sinha, Dementia Specialist and Clin-

The demand for age-focused housing in India is no longer driven by compulsion, it is increasingly being shaped by lifestyle needs and peace of mind

Ankur Gupta
Joint MD, Ashiana Housing

The single most transformative change India can make is to strengthen an integrated primary care ecosystem linked with home-based services

Dr Ritu Rana
Mission Head- Healthcare, HelpAge India

Care must function as a continuum: spanning home care, day programs, rehabilitation, and residential care

Neha Sinha
Dementia Specialist and Clinical Psychologist, Co-founder & CEO, Epoch Elder Care

ical Psychologist, Co-founder & CEO, Epoch Elder Care adds, "In India, particularly, the emotional dimension of caregiving is significant." For many households, relying on informal support is not a choice but a necessity born of limited alternatives.

For emerging service providers, this has meant rethinking delivery models. Gaurav Dubey, Founder and CEO, Livlong 365 observes that models which rely less on physical infrastructure and more on distributed care, including home-based services, may be better suited to bridge these gaps. While still evolving, such approaches are beginning to extend care into regions where institutional infrastructure has yet to reach. The challenge, then, is not just building capacity, but ensuring it aligns with where ageing is actually taking place. Which, in turn, shifts the conversation from infrastructure alone to the very idea of care itself.

Care, redefined

As India's elderly population grows, care is no longer being defined solely by where it is delivered, but by how continuous and accessible it can be.

At the centre of this shift is a gradual move away from episodic, facility-led care towards models that extend beyond hospital settings. As Dr Rana explains, "elderly care requires ongoing management of chronic conditions, including functional decline and psychosocial needs," adding that this is most effective when delivered closer to home. Her point reflects a broader transition. Ageing is not a one-time medical event. It is a long-term care journey.

This is where home-based care is gaining ground, not as a substitute, but as a necessary extension of the system. Dubey opines, "home healthcare is moving beyond convenience to becoming a core part of how chronic care is delivered, especially for elderly patients." The model allows for continuity, something traditional systems have struggled to provide at scale.

From a systems perspective, the shift is also being driven by gaps in existing infrastructure. As Sinha points out; "Care remains largely hospital-centric, while the critical stages between treatment and recovery are often missing," which creates friction when dealing with ageing populations that require sustained engagement rather than intermittent intervention.

Even within institutional settings, the expectation is beginning to change. According to Anand, the future lies in "integrated care pathways where hospital, home care, and assisted living are not separate silos but part of the same continuum." This signals a shift from isolated service delivery to coordinated ecosystems.

Yet, this transition is still underway. As Mishra observes, "the real test will be whether these models can scale beyond early adopters and become accessible across income segments." Affordability and reach, not just innovation, will determine how widely these models can be adopted.

The longevity shift

As care models begin to evolve and private players expand their role, the question of system-level support becomes harder to ignore. Infrastructure, after all, does not scale in isolation. It requires policy direction, financing frameworks, and a workforce equipped to handle the realities of ageing.

India has taken early steps in this direction through initiatives such as the National Programme for Health Care of the Elderly (NPHCE), aimed at strengthening services for older populations. However, the gaps between framework and execution still exists.

Globally, ageing societies have approached this transition with more structured systems. Countries such as Germany and Sweden have built integrated ecosystems that combine residential care, assisted living, and home-based services within formal long-term care frameworks. As Mishra states, "these systems did not emerge overnight. They evolved with sustained public investment and clear policy prioritisation of ageing as a long-term economic and social issue."

For India, however, replication may not be straight forward. As Dr Rana emphasises, the country will need "a customised approach" that builds on family and community-based care, while strengthening formal systems around it. The path forward is likely to be hybrid, balancing institutional infrastructure with home-based and community-led models.

From an industry lens, this also raises questions of affordability and scale. Anand points out that "for elderly care to truly scale, it has to move beyond premium segments and become accessible across income groups." Without that, organised infrastructure risks remaining limited to a narrow slice of the population.

This brings the conversation back to a simple, but unresolved question. Not whether India will age, but whether it will be prepared when it does.

Because the measure of a developed system is not only how it builds for its present, but how it plans for those who will grow old within it.

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SMBT Sevabhavi Trust becomes first educational institute in Maharashtra to receive 'Great Place to Work' certification, setting new benchmark

Recognition highlights the growing importance of workplace culture in healthcare education, with strong employee trust and organisational alignment

SMBT Sevabhavi Trust has received the prestigious Great Place to Work® certification, a globally respected recognition of workplace excellence. With this achievement, the Trust has become the first educational institution in Maharashtra's medical education and healthcare sector to receive this international honour, marking a significant milestone for the academic and healthcare community.

This recognition highlights the increasing importance of workplace culture in institutions that play a critical role in shaping future healthcare professionals. In environments where teaching, clinical care, and teamwork intersect, the quality of the workplace directly influences outcomes for both students and patients. The certification brings focus to the need for institutions to prioritise employee experience alongside academic and clinical excellence.

The evaluation process involved a detailed Trust Index Survey and Culture Audit, assessing key parameters such as credibility, respect, fairness, pride, and teamwork. Participation from doctors, faculty members, nursing staff, and administrative teams reflected a high level of engagement across the organisation. The results indicated strong alignment between leadership and employees, supported by a 97 per cent trust score.

Over the years, SMBT has expanded its academic programmes, healthcare services, and infrastructure. Alongside this growth, it has maintained a consistent focus on building a work environment where individuals feel respected and supported. Policies centred on equal opportunity, transparency, and professional development have contributed to a stable and constructive workplace. Institutional leadership has also focused on ensuring employees feel valued, leading to better coordination across teams and improved overall functioning, contributing to consistent academic and service standards.

SMBT emerges as a people-focused institution, where trust, inclusive culture, and leadership commitment drive excellence in healthcare education and workplace standards

Dr Mahesh Gabhane, Chief People Officer stated that consistent efforts have been made to build a strong and uniform work culture across all SMBT institutions, including MBBS, BDS, BAMS, Nursing, Physiotherapy, Pharmacy, and SMBT Hospital. With more than 4,000 students (UG and PG) and over 2,500 employees, including superspecialists and consultants, the focus has been on creating a transparent, inclusive, and engaging work environment. These sustained initiatives have significantly improved employee satisfaction and contributed to establishing SMBT as a 'Great Place to Work' campus.

The recognition has wider importance for the sector. It shows that healthcare institutions can set high standards not only in academics and patient care but also in workplace culture. Because of its strong focus on academic excellence and affordable healthcare, SMBT has been successful in attracting committed and purpose-driven people. This has helped build a high-performing and dedicated team, driving excellence and long-term institutional success.

Dr Harshal Tambe, Managing Trustee, SMBT Educational Trust, "This recognition reflects the collective commitment of our people and the values we uphold every day. At SMBT, we work on strong pillars of quality education, affordable healthcare, and being a great place to work. A respectful, transparent, and inclusive environment enables our people to perform their best and contribute meaningfully to society."


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This is to certify that SMBT Sevabhavi Trust has successfully completed the assessment conducted by Great Place To Work®, India, and is certified as a great workplace.

This certificate is valid from March 2026 till March 2027.

Balbir Singh
Chief Executive Officer
Great Place To Work®, India

Note: The certificate is valid subject to the terms and conditions agreed to by the Organization.

Hospital violence and its mangement: A critical concern for healthcare delivery

Prof Soumya Ranjan Mishra, CEO of Chittaranjan Seva Sadan, Odisha, draws attention to the alarming rise in violence against healthcare professionals across India and globally

We are quite aware on the issues of Violence in Hospitals pan India & abroad. There are instances of physical or verbal violence happening every day in any of the public / private hospitals in India. This growing trend of violence in hospitals is putting a major negative impact on healthcare personnel as well as promoters in healthcare sector. As a result, the enthusiasm for delivering better healthcare is gradually being suppressed in many areas. Urban as well as rural hospitals are exposed to and facing such incidents.

The need of the hour is effective and acceptable methods to manage incidents of violence in hospitals along with preparation for preventing these. Almost every hospital's administration must be willing to or seeking technical help in designing an effective 'Hospital Violence Management Program' implementable in their organisations.

Being into healthcare / hospital sector for last 20 years, leading a rural hospital as the CEO along with teaching students of Healthcare & Hospital Management, I felt the urge since long to design a feasible management module to deal with hospital violence. The training program titled 'Self-defense for hospital personnel' is in its final draft phase & if possible, will reach every healthcare personnel once finalised and accepted by leaders in healthcare sector.

For self-defense, basic things to keep in mind while working in hospital:

● Prioritise your safety to sustain compassionate service. Duty to care must coexist with duty to self.

● Remember the sources of violence in healthcare. It may be Patients, Patient's attendants, intruders, or other staff too.

● Common triggers for aggression: Long waiting time, cost concern, perceived negligence, negative treatment outcomes, communication gap, etc.

The need of the hour is effective & acceptable methods to manage incidents of violence in hospitals along with preparation for preventing these. Almost every hospital's administration must be willing to or seeking technical help in designing an effective 'Hospital Violence Management Program' implementable in their organisations

● Situational awareness at workplace can help sense any upcoming event of violence. Hence one should have-

◆ Relaxed Alertness in general

◆ Focused alertness to identify & monitor specific threats or unusual behaviour.

◆ Action Mode to take decisive action (fight or flight mode).

● Recognising pre-attack indicators as follows-

◆ Physical signs of escalation (watch for clenched fists, pacing, rapid breathing).

◆ Facial Expression matters (notice Jaw clenching, distant stares and colour changes).

◆ Verbal warning signs (Sudden silence or abrupt single-word responses signal risk).

● The reactionary gap –

◆ Maintain at least 2 arm's length distance from violent individuals.

◆ Ensure clear exit paths & never allow anyone to block your escape route.

◆ Visualise your safety radius by identifying safety routes & maintaining spatial awareness.

● Legal framework (your rights)-

◆ Know your legal rights for self-defence as there are sections that empower you to defend yourself.

◆ Defend with reasonable force i.e. only use force necessary to protect your body and property.

◆ Balance threat & response i.e. excessive force should not be permitted – match defence to threat.

● Documentation & reporting –

◆ Written records are essential. Document every incident to ensure accountability.

◆ Report all threats promptly. Include verbal, physical & non-physical threats.

◆ Use exact quotes in reports. Record the actual words used, for clarity & evidence.

● Panic protocols-

◆ Know your emergency code/ contact. Familiarise yourself with hospital's violence alert protocol (if in effect).

◆ Identify key responders. Understand who responds quickly – security, colleagues, or both.

◆ Follow established steps to ensure safety & support (if in effect).

Other essential considerations to be adopted (if acceptable by hospital's administration):

● CCTV surveillance with prompt response.

● Community association with public leaders to manage mass violence.

● Established protocols for instant gathering of designated personnel of hospital in response to violence.

● Intimation of 'Emergency Code' for responding in case of violence (Most acceptable is code- white).

● Psychological support as post incident counselling to empower hospital personnel prepare for future events of violence & manage mental trauma.

● Other than individual or institutional effort, managing or reducing events of hospital violence could be possible if-

● Government machinery enacts stringent rules to punish individuals resorting to violence in hospitals and that too promptly.

● Registered medias start working for awareness of these rules within the public.

● Hospitals ensuring strict adherence to ethics in each & every department.

● Professionals working in healthcare / hospital sector & students in healthcare stream being trained in proper management of hospital violence with self-defence.

● Proper analysis of 'situations' responsible for regular dissatisfaction of patients, beneficiaries or staff in hospitals, & timely rectification of those causes.

● Last but not the least, staff working in hospitals should be trained in ' communication skills & behaviour' pertinent to healthcare sector.

INTERVIEW

Alcon's broader commitment is helping people see brilliantly

Amar Vyas, Country Head – India, Alcon analyses the recently launched Alcon Unity VCS and CS platforms, focusing on the purpose and engineering driving the future of phaco-vit treatment

Give us an overview of Alcon and where it fits into India's need for good quality eye care.

Alcon has a legacy of more than 75 years globally. Over more than seven decades, we have evolved from a small pharmacy that started with pharmaceuticals to the world leader in eye care.

We are the market leader across almost every segment where we operate in surgical — whether cataract, vitreoretinal (VR), or refractive. Over the past few decades we have seen significant innovation, not only from an industry perspective but also in the way surgeries are performed—from relatively basic procedures to highly innovative, technology-intensive surgeries today.

Alcon has played a very significant role in each of these segments. When it comes to phaco was one of the biggest game-changers in how cataract operations are performed. Alcon has been a pioneer in that segment, bringing new and innovative products over the years—from legacy systems to newer platforms developed over the past three decades, including INFINITY®, CENTURION® Vision System, and now UNITY® Cataract System (CS).

In vitreoretinal surgery as well, we have moved from the ACCURUS® Surgical System to the CONSTELLATION® Vision System, and now to the UNITY® Vitreoretinal Cataract System (VCS). The same holds true for refractive lasers—from LASIK equipment to WaveLight® Plus, a fully personalised LASIK solution powered by

ray tracing technology.

There has been a great deal of innovation, and Alcon has always been at the forefront in bringing best-in-class technologies. When we talk about the best technology, it ultimately translates into greater comfort for surgeons, better outcomes, and higher patient satisfaction. That is where we are now leading with our latest innovation—the Unity portfolio, especially the Unity VCS and CS.

The Alcon Unity VCS and CS introduced more than a dozen first-to-market innovations. What core surgical challenges were you aiming to solve with this platform? What was the engineering philosophy guiding its development?

Like most innovations from industry leaders, Alcon's development process incorporates multiple perspectives. Most importantly, we continuously take inputs from surgeons who understand what is required to deliver the best outcomes for patients.

If I were to highlight a few key considerations that guided the development of this platform, one would be high surgical volumes. As populations grow and age, surgical demand continues to increase.

Second is the aging population. While India today has one of the youngest populations globally, over time we will also become one of the countries with a very large aging population.

The third factor is throughput demand, which is particularly relevant in countries like India. India performs the highest number of cataract surgeries globally around 8 million procedures annually. At the same time, we have an estimated ratio of about one ophthalmologist per 100,000 people. This places considerable pressure on surgeons not only to perform surgeries effectively but also to perform them at higher volumes.

Platforms like the Unity VCS and CS help address these challenges by delivering superior efficiency that supports both vitreoretinal and cataract procedures. They also help streamline operating room workflows and system set-up for surgical procedures when used as directed, based on documented workflow evaluations.

Another important factor in India is the prevalence of complex cases. Many patients seek medical attention when the disease has already progressed significantly. In such cases, especially dense or complicated cataracts, having stable and highly efficient equipment becomes critical.

For us, this aligns with the broader public health goal of restoring vision safely and quickly. Alcon's commitment has always been to bring next-generation technologies that transform the way eye care is delivered—not just incremental improvements, but meaningful advances that change the landscape of ophthalmic surgery. The Unity VCS and CS platforms are designed with that goal in mind.

What has been the market response to these systems?

We introduced the Unity VCS, which is the combined platform for both vitreoretinal and cataract surgery in August 2025 in India at the Asia-Pacific Association of Cataract and Refractive Surgeons (APACRS) Annual Meeting. Later, in December, we commercially launched the standalone cataract system, the Unity CS.

The response has been phenomenal. I would also like to credit Indian surgeons for this. Surgeons in India are highly innovative and are always willing to adopt the best technologies. They are willing to invest if the technology delivers real value.

In the last few months, we have already seen a good number of installations across India which is a very encouraging start. The feedback from surgeons has been extremely positive. Many feel this represents a transformational improvement compared to earlier technologies.

Are these installations mainly in metro cities?

Over the past decade we have seen tremendous transformation in India's healthcare landscape. When I started my career almost three decades ago, advanced technology was largely limited to metro cities and economically developed states.

Today, even smaller towns are performing world-class surgeries. It is not uncommon to see top-quality procedures in Tier-3 or even smaller cities.

The adoption of technology has spread widely across the country. With Unity VCS and CS, we are seeing the same trend. The installations are not limited to metros like Mumbai, Bengaluru, or Chennai. For example, we already have installations in Meerut, and

others in places like Bihar and several other regions.

So adoption is happening across the country, not limited by city tier.
So in a sense, this is democratising high technology and taking advanced eye care to smaller cities.

That is absolutely correct. It is very heartening to see that patients no longer need to travel long distances to access quality eye care.

Cataract care and eye care in general has become widely available across India. Patients usually just need to identify the right doctor or facility, but in most cases they no longer need to travel long distances, which was common earlier.

Moving to your next technology—HyperVit 30K. It is the world's fastest vitrectomy probe at 30,000 cuts per minute. Beyond speed, what makes this advancement transformative for vitreoretinal surgery?
The HyperVit 30K cutter, which is part of the Unity VCS system, is used in vitreoretinal surgeries. As you mentioned, it operates at 30,000 cuts per minute, making it extremely fast—about 50 per cent faster than current cutters.

But it is not just about speed. The cutter has been engineered to deliver both speed and control. It enables surgeons to perform vitreous removal with smoother, more controlled motion, delivering efficient and stable performance.

From the surgeon's perspective, the combination of speed and control increases confidence especially in complex cases. Confidence becomes very important when dealing with difficult surgical situations.

From the patient's perspective, faster procedures can reduce surgical time, which improves comfort and reduces anxiety.

Overall, the benefits extend to the entire surgical ecosystem—surgeons, operating room staff, and patients—because the workflow becomes stable and efficient. The result is faster

nucleus removal than OZIL, precise control IOP, and excellent outcomes.

As this is a very high tech system, it brings speed and stability, so you need to be more precise, etc. Is there a training aspect to the services that Alcon provides?
The fundamental procedures for phaco or vitrectomy surgery remain the same, so most surgeons are already well-versed in the techniques.

However, with new technology there are certain nuances—such as parameter adjustments, workflow changes, and machine settings. Our trained specialists and engineers work closely with surgeons and operating room staff during the transition phase to ensure they are comfortable with the system.

Indian surgeons adapt very quickly, so the transition period is usually short.

In addition, as installations grow, we also plan to establish Centres of Excellence where surgeons can observe procedures and gain deeper familiarity with the technology. But in most cases, our in-house teams provide all the necessary training and support.

Moving to the Unity 4D phaco system. It delivers up to twice-as-fast nucleus removal than Ozil with significantly less energy. What is fundamentally different about this technology?
I will compare it with our current technology on phaco and nucleus removal, called the Ozil technology, which has long been considered Alcon gold standard in phaco systems for ultrasound delivery during nucleus removal.

The 4D phaco technology represents a new modality of ultrasound delivery inside the eye.

Internal bench testing suggests that nucleus removal can be up to two times faster compared to Ozil technology. At the same time, the energy delivered into the eye is around 41 per cent lower.

This has several implications. Faster surgery improves patient comfort and allows surgeons to perform procedures efficiently within the existing operating schedules—important in a country like India with very high surgical demand.

Lower energy delivery also means less stress on ocular tissue, which can reduce complications and support faster post-operative recovery.

This can be particularly helpful for patients who travel for surgery or come from remote areas. With faster recovery times, they do not need to remain in the city for extended follow-up periods.

The Unity Intelligent Fluidics system allows surgery at more physiological intraocular pressure (IOP). How does this work?
The Unity Intelligent Fluidics system represents an advancement in real-time pressure and flow control. It continuously monitors parameters inside the eye, including intraocular pressure.

The system intelligently regulates IOP throughout the procedure.

Operating under more physiologic IOP makes the procedure comfortable for patients particularly during complex cases.

At the same time, the system allows surgeons to maintain stable performance across a wide range of surgeon selected settings within labeled limits, including the use of higher vacuum levels when necessary, while maintaining stability.

Features like Unity Intelligent Sentry introduce active monitoring during surgery. How do these innovations improve safety?
These technologies provide active anterior chamber surge mitigation. During cataract surgery, fluid flows into and out of the eye. Maintaining the right balance is critical. If the balance is disrupted, it can cause fluctuations and chamber instability.

The system uses proprietary sensors and dual-vent valve technology to actively monitor and maintain intraocular pressure, enabling stable chamber behavior without compromising followability during surgery.

This is especially important during occlusion break events, when the nucleus fragment being emulsified suddenly releases. These moments can cause pressure fluctuations.

The real-time sensing system stabilises the chamber, ensuring the surgeon can continue the procedure with confidence.

While this stability may not be critical in straightforward cases, it becomes extremely important in complex surgeries or pathological eye conditions.

How do Unity VCS and CS strengthen Alcon's leadership in ophthalmic innovation?
Unity VCS and CS are the first technologies in what will become a Unity platform ecosystem.

It is designed to create a seamlessly integrated environment connecting operating room systems and diagnostic equipment in the outpatient department. All these platforms will communicate with each other, allowing clinicians to access integrated data across systems.

Ultimately, the goal is to create a future-ready ophthalmic operating room where surgical systems and diagnostics work together seamlessly.

This reflects Alcon's unwavering purpose: helping people See Brilliantly, a commitment that guides everything we do. As the global leader in eye care, we continuously advance bold innovation and bring best-in-class technologies across cataract, refractive, vitreoretinal, and emerging areas such as glaucoma. And Alcon has a long legacy of advancing phacoemulsification and vitreoretinal technology for surgical ophthalmology.

Backed by one of the industry's most robust R&D engines, and powered by advanced technologies seamlessly integrated across our platforms, we are committed elevating clinical practice while expanding access to life changing vision solutions for patients in India.

Innovations in Cannula Tubing: Silicone cut piece tubes as non-returnable valves

Silicone cut piece tubes are essential components in modernmedical tubing applications, particularly as non-returnable valves(NRVs) in fluid management systems. These precision-cut siliconetubes ensure one-way fluid flow, preventing backflow andcontamination in critical medical and industrial applications. Thisarticle explores the manufacturing process, quality controlmeasures, and machinery used in the production of high-qualitysilicone cut piece cannula tubing.

MANUFACTURING PROCESS OF SILICONE CUT PIECE CANNULA TUBING

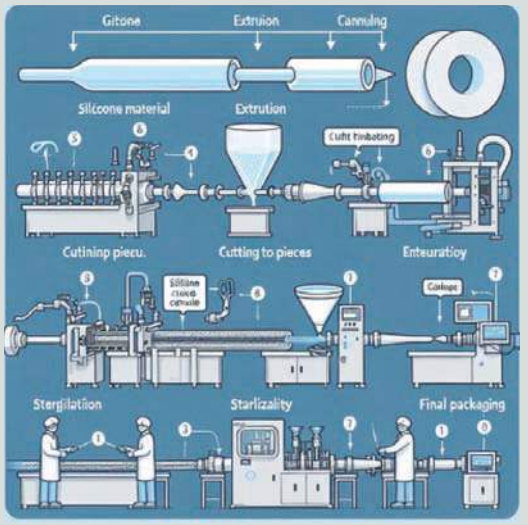
The production of silicone cut piece tubing involves several precise steps to ensure uniformity, durability,and biocompatibility. Below is a breakdown of the key stages in the manufacturing process:

Raw Material Selection &Preparation

- Medical-grade silicone elastomer is used as the basematerial, ensuring compliance with USP Class VI andISO 10993 standards.
- The raw silicone is compounded with additives toenhance elasticity, strength, and biocompatibility.
- The silicone mixture undergoes vacuum de-airing toremove trapped air bubbles, ensuring a uniformconsistency.

Extrusion Process

- The prepared silicone is fed into an extrusionmachine, where it is shaped into tubes of the requireddiameter and wall thickness.
- A precision-controlled extrusion die determines thetubing dimensions.
- The tubing undergoes a continuous curing process(heat or UV curing) to achieve the desired mechanicalproperties.



Cutting & Sizing

- Once the extruded tubing is ready, it is cutinto specific lengths using automatedcutting machines.
- The cut pieces are carefully measured toensure tight tolerances and uniformity.

Surface Treatment &Finishing

- The cut pieces may undergo plasma treatmentor chemical treatment to enhance surfaceproperties, such as adhesion andbiocompatibility.
- Post-treatment, the tubing is cleaned usingultrasonic washing to remove any residues orparticles.

Curing & Sterilization

- The tubing undergoes an additional heat-curing process to enhance durability andflexibility.
- Sterilization methods like gammairradiation or autoclaving ensure medicalsafety.

QUALITY CONTROL & IDENTIFICATION OF THE FINAL PRODUCT

Ensuring the highest quality standards is crucial in medical-grade silicone tubing. The following qualitychecks and identification processes are implemented:

Dimensional Accuracy& Visual Inspection

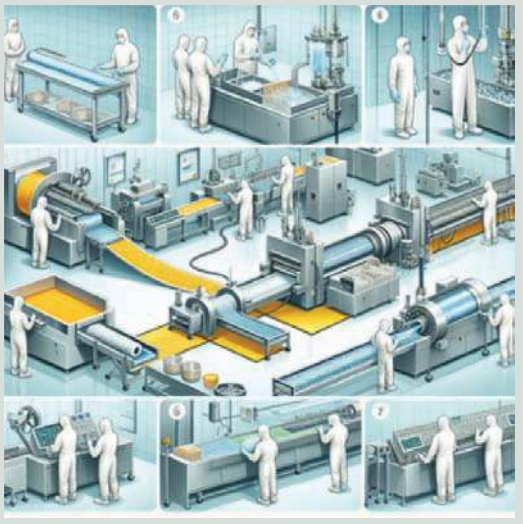
- Automated laser measurement systems verifythe tube's inner and outer diameters.
- Each batch is visually inspected for defects,inconsistencies, or contamination.

Biocompatibility &Material Testing

- The final product undergoes cytotoxicity,hemocompatibility, and extractables testing toconfirm patient safety.
- Tensile strength, elongation, and elasticity testsensure that the silicone tubing meets industrystandards. Manufacturing

Flow & Seal IntegrityTesting

- The self-sealing functionality of the siliconecut piece tube is tested using pressure andfluid flow analysis.



- The tubes are tested under differentpressure conditions to confirm theireffectiveness as non-returnable valves.

Batch Coding &Traceability

- Each batch of silicone cut pieces is markedwith traceability codes, allowing tracking ofproduction date, material lot number, andcompliance certifications.
- Final products are packaged in sterile, airtightpouches to maintain their integrity duringstorage and transportation. www.

MANUFACTURING MACHINES USED IN PRODUCTION

The production of silicone cut piece cannula tubing involves specialized machinery designed forprecision and efficiency:

Silicone Extrusion Machines

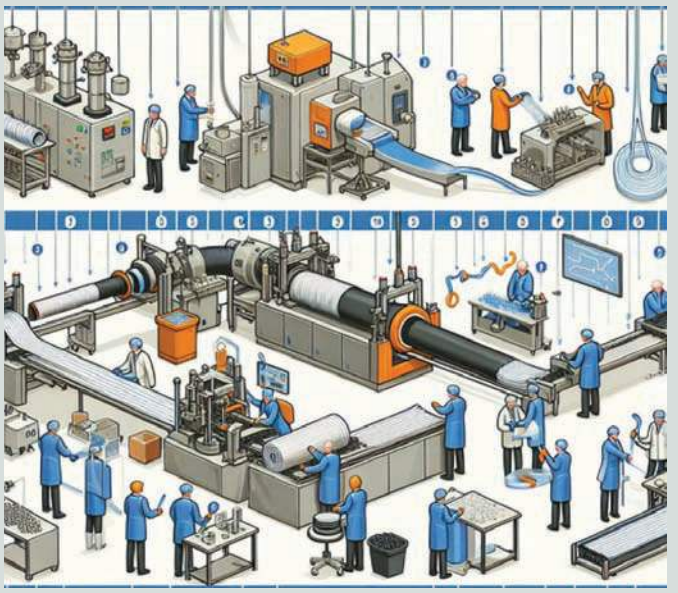
- Used for shaping raw silicone into tubingwith precise diameter, thickness, andelasticity.
- Equipped with real-time monitoring toensure consistent output.

Automated Cutting Machines

- High-speed automated slicers ensure thattubing is cut to uniform lengths with tighttolerances.
- Equipped with laser-guided cutting forextreme precision.

Curing Ovens

- Used to vulcanize and solidify siliconetubing, ensuring durability and flexibility.
- Provides uniform heat distribution toprevent defects.



WHY CHOOSE AMI POLYMER SILICONE CUT PIECE CANNULA TUBING?

At Ami Polymer Pvt. Ltd., we specialize in manufacturing high-precision silicone tubingtailored for medical and industrial applications. Our expertise ensures:

- Compliance with Global Standards – We adhere toUSP Class VI, ISO 10993, and FDA guidelines.
- Customizable Solutions – Available in various sizes,hardness levels, and wall thicknesses.
- State-of-the-Art Manufacturing – Precision extrusion,cutting, and quality control ensure consistentperformance.
- Sterility & Safety – All products undergo rigoroustesting and sterilization to guarantee patient safety.
- End-to-End Quality Assurance – Each batch issubjected to dimensional, material, and functional testing.

CONCLUSION

The use of silicone cut piece tubes as non-returnable valves represents a major advancement in fluidmanagement systems. Their ability to prevent backflow, enhance sterility, and ensure reliable fluid flowmakes them essential in medical, pharmaceutical, and industrial applications.

At Ami Polymer Pvt. Ltd., we are committed to delivering superior-quality silicone tubing solutions that meetthe highest safety and performance standards. For customized solutions or technical inquiries, reach out toour team today!

Reimagining access to advanced imaging in India

A key enabler of Truevis'sgrowth is its focus on buildingstrong multidisciplinary teamsacross engineering, clinical ap-plications, installation, andservice operations

India's healthcare landscape is at an inflection point, where advanced diagnostics are no longer optional they are central to improving clinical outcomes. The rising burden of cancer, cardiovascular diseases, neurological conditions, and other chronic illnesses has made early and accurate diagnosis a clinical necessity rather than a luxury.

Technologies such as CT, MRI, PET-CT, and advanced radiology systems are increasingly defining how clinicians detect, monitor, and treat diseases. Yet, despite this growing importance, access to such technologies remains uneven. While metropolitan hospitals are well-equipped, large parts of Tier-II and Tier-III India continue to face gaps driven by high capital investment, complex installation processes, and long-term service challenges.

This gap presents a critical opportunity- not just to expand infrastructure, but to rethink how advanced imaging is delivered.

Beyond equipment: Building a holistic imaging ecosystem

Truevis Technologies Pvt Ltd is positioning itself at the centre of this transformation by moving beyond the traditional role of an equipment supplier. Instead, the company is building a comprehensive imaging ecosystem designed to simplify adoption and improve operational outcomes for healthcare providers.

Its portfolio spans the full spectrum of radiology, including CT, MRI, DSA, and PET-CT systems. However, the core differentiator lies in its integrated approach—combining technology deployment, installation, clinical application support, and lifecycle service into a unified model.

This approach enables hospitals and diagnostic centers to adopt advanced imaging solutions with greater confidence, minimizing the operational and technical complexities that often act as barriers to entry.

Execution at scale: Strengthening technical and clinical capabilities

A key enabler of Truevis's growth is its focus on building strong multidisciplinary teams across engineering, clinical applications, installation, and service operations.

By bringing together experienced professionals from global imaging organizations, the company has created a robust execution backbone capable of supporting large-scale deployments. These teams play a critical role not only during installation and commissioning, but also in optimizing workflows and training clinical users.

As deployments expand across regions, this strong service infrastructure ensures faster turnaround times, higher system uptime, and a more reliable experience for healthcare providers—an increasingly important differentiator in the imaging industry.

Localisation as a strategic advantage

At the heart of Truevis's strategy is a clear focus on localized manufacturing and system integration. The company is establishing its manufacturing presence at the Andhra Pradesh MedTech Zone (AMTZ), Visakhapatnam, one of India's most prominent medical technology clusters.

Local manufacturing enables significant cost optimization, improved supply chain control, and faster service response. More importantly, it reduces the total cost of ownership for hospitals, making advanced imaging solutions more viable for emerging markets.

This strategy aligns closely with India's broader push toward strengthening domestic MedTech capabilities and reducing dependence on imports for high-end healthcare technologies.

Global technology, local impact

Truevis's capabilities are further enhanced through its collaboration with Neusoft Medical Systems, a globally recognized imaging technology provider.

This partnership focuses on technology transfer, platform localization, and structured training programs tailored to Indian clinical environments. By combining global innovation with local execution, the collaboration creates a scalable and sustainable model for expanding access to advanced imaging.

Expanding the reach of precision diagnostics

As India continues to invest in healthcare infrastructure, the role of advanced diagnostics will only grow stronger. Bridging the gap between urban and emerging healthcare markets is essential to improving early detection rates and overall patient outcomes.

With a growing order pipeline, expanding operational teams, and installations underway across multiple regions, Truevis Technologies is playing a pivotal role in shaping this next phase of diagnostic expansion.

By integrating global technology, local manufacturing, and end-to-end service capabilities, the company is not just delivering imaging systems—it is enabling a more accessible, reliable, and future-ready diagnostic ecosystem for India.

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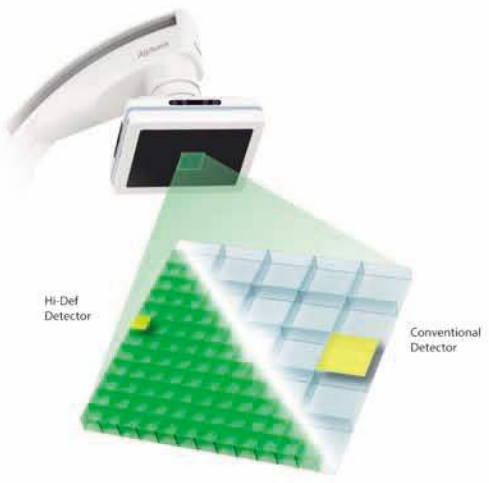

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